# SOUTH DAKOTA BOARD OF NURSING

SOUTH DAKOTA DEPARTMENT OF HEALTH
4305 S. Louise Avenue Suite 201 ♦ Sioux Falls, SD 57106-3115
(605) 362-2760 ♦ FAX: 362-2768 ♦ www.state.sd.us/doh/nursing


## APPLICATION FOR CERTIFIED NURSE AIDE REGISTRY BY INTERSTATE ENDORSEMENT

This application is required to implement programs authorized by §1819(f) and §1991(f) of Public Law 100-03, the Omnibus Budget Reconciliation Act 1987. Failure to provide information except gender, ethnicity, and social security number will result in denial of your request to be placed on the registry. Gender, ethnicity, and social security number are used for identification and statistical purposes only; disclosure of this information is voluntary; failure to provide it may result in misidentification. This data becomes part of your permanent file, which is a public record.

**APPLICANT: PLEASE COMPLETE THIS SECTION**

NAME: _____
First Middle Last Maiden/Other Names Used

ADDRESS: _____
Street City State Zip

BIRTH DATE: _____ SOCIAL SECURITY: _____ GENDER: ❒Female ❒Male

CERTIFIED NURSE AIDE TESTING SERVICE: _____

CNA TESTING SERVICE ADDRESS: _____

DATE OF WRITTEN EXAM: _____ DATE OF MANUAL SKILLS EXAM: _____

TRAINING SITE: _____ COMPLETION DATE: _____

ETHNICITY: ❒American Indian ❒Asian/Pacific Islander ❒Black ❒Hispanic ❒White

*I authorize the* _____ *Nurse Aide Registry Agency*
(STATE IN WHICH YOU ARE PRESENTLY CERTIFIED)
*to furnish to the South Dakota Board of Nursing the information requested below.*

SIGNATURE OF NURSE AIDE: _____ DATE: _____

**NURSE AIDE REGISTRY AGENCY: PLEASE COMPLETE THIS SECTION**

❒ The information on this form is accurate and the above-named person is on the Nurse Aide Registry in our state and meets the OBRA 87 requirements.

❒ The above-named person is not on the Nurse Aide Registry in our state.

NAME OF TESTING SERVICE: _____

TESTING LOCATION: _____

DATE OF WRITTEN EXAM: _____ DATE OF MANUAL SKILLS EXAM: _____

LAST RECORDED PLACE OF EMPLOYMENT: _____

EMPLOYER ADDRESS: _____

Is there any record of abuse or any pending action? ❒YES ❒NO

If YES, please give a brief summary of abuse and action taken.

STAMP OR SEAL

SIGNATURE OF AGENCY REPRESENTATIVE: _____
TITLE: _____
STATE: _____
DATE: _____

*Agency Representative: Please mail completed form to South Dakota Board of Nursing at the address above.*